PRIVATELY INITIATED ASSURANCE PROGRAMS*

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It may surprise members of the younger generation that, except for licensure, many of the functions we are discussing in today's session existed before federal and state governments got into the health care act in a major way. The program of the American College of Surgeons that was inherited by the Joint Commission on Accreditation of Hospitals dates back from the early 1920s. Hospital planning began in New York City in 1938 through the Hospital Planning Council of Southern New York, which was headed by John Pastore at that time. Claims review is a quality control function that insurors of all kinds have been conducting for many years. These programs existed and worked for the public benefit before government was paying a significant part of the health care bill.

Today the political pendulum has swung in the other direction. The American people have elected a new president and even those of us who disagree with the administration's new policies will learn to adapt to a changing environment. The Health Systems Agencies, a major part of the current health planning function in the country, may or may not go down the drain ... but it is quite likely that these agencies may be shrunk significantly. The American Hospital Association counts 35% of its hospital members as being part of a multi-institution system. Looking around New York City, one can without any difficulty count five such systems making up a significant percentage of the hospitals in New York City.

Whenever an institution has to decide where to put its resources there is a planning function. This planning function takes place in for-profit chains and in not-for-profit chains, and is concerned with location and demography, issues that also concern the Health Systems Agencies. Cor-

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porations have to study what the customer wants, and whether the type of facility they planned is needed.

Planning and marketing are thus combined when this function is carried out. This process is taking place at such firms as the for-profit Humana, the Hospital Corporation of America, at the Lutheran Home and Hospital System in the midwest, and at the Intermountain system for the not-for-profits.

During the last 10 years, several slogans received wide circulation and elicited strong emotional responses: "Health care is a right," "Health care should be comprehensive and of high quality, coordinated with teaching and research." "We need an adequate mixture of primary, secondary, tertiary care." The problem is that we cannot achieve all these goals for the health care system at the same time and in the same amounts. We must choose among various goals and assign relative priority rankings to them. In the mid-1960s we had a growth of the Office of Economic Opportunity Neighborhood Health Centers. Later we emphasized primary care. Then physician assistants, nurse practitioners, and CAT-scanners came on the horizon. The current catchword is competition. My fear is that this movement will tend to downgrade teaching and research. One cannot compete on a price basis when the institution has a teaching load on its back. Automatically the costs are higher. Program emphases will continue to change. Tradeoffs have to be made because we are not talking about either/or, we are talking about priorities for this country.

What is the difference between the voluntary approach to planning and the governmental approach? First let us agree that there are no evil spirits, there are no conspiracies. The main difference lies in the reward system. The Joint Commission on the Accreditation of Hospitals from the very beginning emphasized education, with a small club in its back pocket. For example, one year of accreditation may be given instead of two years, but very rarely no accreditation at all. This incentive system has worked, hospitals have responded. The government, on the other hand, is in a difficult spot. With its reliance on law and lawsuits and fiscal sanctions, government cannot do much by way of education. Further, the people that government attracts are underpaid, and because of this they may be of lower quality. There are some who are highly motivated or who are competent and some who are zealots, but the good ones do not last very long. They get bored because they dislike the rigidity or the low pay, and they move on. In some jurisdictions, salaries are set at a low

ceiling because legislators will not permit any civil servant other than the chief executive to make more than they do. The governmental system is a rigid system as opposed to an open, flexible, professionalized, and educationally oriented system.

Another issue that troubles hospitals is that half a dozen quality assurance programs are going on in any one hospital at the same time. It is absolutely impossible for hospitals to function if one third-party payer or another government agency requires data to be presented in different formats. A minor variation could mess up the whole system. In New York State we are developing a system known as the State Planning and Research Cooperative System. Every hospital in the state must file a discharge data abstract on every single inpatient discharge, either directly or indirectly through its data-processing service. Third parties generate a tape of a common bill from a uniform billing form using a hospital identification number as the tracker, and all the information from all sources is merged into one record. New York is the only place that I know where 100% of discharges or some two and one half million discharges in the state are merged into one system. Rapid progress is being made and soon we shall be seeing some output tabulations.

In this panel discussion I would have liked to have heard more concern expressed about the outcomes of medical care. Efficiency is important, but outcome is important too. If Professional Standards Review Organizations are eliminated, who will review what the physicians have accomplished? Who will look at the infection rate or the complications rate for various procedures? What will happen to patients when they leave the hospital? What happens to patients with heart disease after five years? One cannot plan for health care either in the city or elsewhere without knowing what happens to people over the total course of their illness. In a study of discharge planning we looked at elderly patients discharged from hospitals and followed them for only five months because we had limited funds. We found that people move around on their own, and that the discharge planning decisions made by physicians, nurses, and social workers do not have a major impact on patients. We do not know very much about what happens to patients after they leave the hospital, and we cannot plan without knowing what is happening to them. It does no good to get a patient out of the hospital a day earlier and then have him bounce back for two weeks to be worked up again. There must be serious tradeoffs between a reduced length of stay and readmission rate.

In New York there is a good deal of talk about competition today. Competition under the Stockman-Gephardt Bill and the planning concept, whether governmental or voluntary, are antithetical. One cannot have open and free competition and have competitors plan the market among them. If one favors market competition then one may be destroying an opportunity for rational regionalization. Which is better? We tried the voluntary mode for the last 20 to 30 years and the compulsory mode for about five or six. I still do not know which is better, but whether the voluntary or compulsory planning system is better than the free market system also remains to be seen. The problem is that under the market system the needs of the poor and medical education may suffer because no one can take care of those needs and survive in the competitive world. Perhaps my bias is showing in this comment.

A balance can be achieved between the voluntary system and government through a public mandate of voluntary systems. For example, an approval of an institution by the Joint Commission on the Accreditation of Hospitals is necessary for the hospital to participate in government programs. The idea of government mandating that something takes place but leaving the operation to a voluntary organization and using the professional approach makes a good deal more sense than having employees regulate the program.

To conclude, someone has said that in the United States we play politics between the 40-yard lines; whenever a government gets too close to the 40-yard line the pendulum swings back. And what will happen? I predict that in the election of 1992 a liberal Democrat will be elected president, and by 1993 we shall have a new Hill-Burton program in this country.